MEDICAL ASSISTANCE
State: North Carolina

PROSPECTIVE REIMBURSEMENT PLAN FOR ICF-MR FACILITIES
PAYMENT FOR SERVICES

.0301 Payment for Services-Prospective Reimbursement Plan for ICF-MR Facilities

All certified intermediate care facilities - mentally retarded (ICF-MR) participating in the North Carolina Medicaid Program are reimbursed on a prospective basis as set forth hereunder, except that state-operated facilities shall be reimbursed their reasonable and allowable costs in accordance with the Medicare principles of reimbursement and with the applicable provisions of this plan. This plan is developed in accordance with the requirement of 42 CFR 447 Subpart C-Payment for Inpatient Hospital and Long-Term Care Facility Services. Providers shall comply with all federal regulations and with the provisions of this plan.

REPORTING REQUIREMENTS

.0302 REPORTING REQUIREMENTS

(a) Financial reports shall include the following:

(1) Budget reports: Each provider shall include appropriate budget information in its application for an initial rate for a new facility:

(A) The budget shall reflect the projected annual operating results of each of two years subsequent to the commencement of operating said facility.

(B) The budget information used to support the Certificate of Need award shall be provided to the Division of Medical Assistance on or before 30 days prior to the enrollments of said facility by the Medicaid program.

(C) Budgets are not deemed to be appropriately filed unless they are properly prepared, in accordance with rules established by the Division of Medical Assistance.

(2) Cost reports: Each facility that receives payments from the North Carolina Medicaid Program shall prepare and submit a separate annual cost report of its costs, a working trail balance related to reimbursement, and other financial information as requested by the Division of Medical Assistance. Providers that have an approved combined uniform rate in accordance with Section .0304 Paragraph (n) of this reimbursement plan shall file a combined cost report that is supported by the individual facility cost reports. For these providers, the combined cost report shall be filed with the Division of Medical Assistance Audit Section while the individual facility cost reports shall be filed with the Division of Medical Assistance Rate Setting Section.

(A) The cost report shall cover a 12 month period, from July 1 to the following June 30, unless another time frame is specified by the Division of Medical Assistance.

(i) A short year cost report shall be filed for facilities certified in the Medicaid program during the year, with the cost report period commencing on the date of certification and ending the following June 30.

(ii) A short year cost report shall be filed for facilities terminated from the Medicaid program during the year, with the cost report period commencing on July 1 and ending on the date of termination.

(B) The cost report shall be submitted to the state on or before the September 30 that immediately follows the June 30 year end. The Division of Medical Assistance may grant an extension of time of up to 30 days for filing the cost report, upon showing of just cause in writing by the provider. For purposes of this Section, “just cause” is an action that is uncontrollable by the provider, such as tornado, hurricane, strong wind damage, etc.

(C) For new facilities a cost report shall be submitted for the period beginning with the date of certification and ending on the following June 30.

(D) The cost report shall be based on the Chart of Accounts specified by the Division of Medical Assistance. The Chart of Accounts includes a description of each account to be used on the cost report. The Chart of Accounts shall be distributed

to each provider by the Division of Medical Assistance. This material is available for inspection and copies may be obtained from the Division at 1985 Umstead Drive, Raleigh, North Carolina 27603 at a cost of twenty cents ($.20) per page. All costs shall be shown on the cost reports in accordance with rules established by the Division of Medical Assistance. A cost report that does not meet the requirements of the Division of Medical Assistance. A cost report that does not meet the requirements of the Division of Medical Assistance is deemed not to be filed.

(E) Currently filed cost reports shall reflect the decisions and judgments expressed by the Division of Medical Assistance auditors on previous cost reports.

(F) All related organizations shall file a Medicaid cost statement identifying their costs, adjustments to costs, and allocations of costs along with the ICF-MR facility's cost report. A home office, or parent company, shall be recognized as a related organization. Auditable records to support these costs shall be made available to the Division of Medical Assistance and its designated contract auditors. Undocumented costs shall be disallowed for Medicaid reimbursement.

(G) Cost reports shall clearly identify related party transactions. Failure to do so many result in the related cost being disallowed for Medicaid reimbursement purposes.

(H) A combined cost report may only be filed for facilities that use the same cost settlement methodology and have a uniform rate, as approved by the Division of Medical Assistance.

(b) Additional information reporting requirements for facilities shall include , but not be limited to, the following:

(1) Each facility providing day treatment services shall be required to submit, in conjunction with the cost report, a separate report itemizing the actual expense attributable to the provision of day treatment services and the actual number of client days associated with said expense.

(2) Each provider operating a facility, upon the request of the Division of Medical Assistance, shall submit statistical data and other information relevant to the administration and operation of said facility. Such reports shall be submitted within the time frames authorized in the request.

(3) Each provider that issues an annual report to its shareholders shall file a copy of said report with the Division of Medical Assistance. Said report shall be filed within 30 days of its issuance to the shareholders.

(4) Each provider that has a compensatory stock option plan shall file a copy of said plan with the Division of Medical Assistance, within 30 days of its implementation.

(5) A provider shall file an information report with the Division of Medical Assistance within 30 days of receiving notification from either the North Carolina Department of Revenue or the Internal Revenue Service that items, previously reported and allowed on a cost report, have been disallowed on the provider's associated tax return.

(c) Requirements for certification of financial reports.

(1) Each provider that operates a facility shall complete the required financial reports in accordance with the following rules and in the order of priority stated:

(A) Cost shall be represented in accordance with the specific provisions as set forth in this Plan.

(B) Costs shall be reported in conformance with the Medicare Provider Reimbursement Manual, HCFA-15, which is hereby incorporated by reference including subsequent amendments and editions. Said manual is commonly referred to as the HCFA-15 manual and is available for inspection at the Division of Medical Assistance, 1985 Umstead Drive, Raleigh, NC 27603. Copies may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325 at a cost of three hundred fifty seven dollars ($357.00). Tel: (202) 783-3238.

(C) Costs shall be reported in conformance with generally accepted accounting principles.

(D) Governmental institutions have the option of using the accrual or cash method of accounting.

(2) Cost reports prepared for facilities shall be certified for their compliance with Subparagraph (c)(1) of this Section by the provider's executive director or designated officer.

(3) Budget reports prepared for facilities shall be certified for their fair representation of anticipated disbursements and receipts related to the Medicaid ICF-MR program by the provider's executive director or designated officer.

(d) Requirements for the revision of financial reports shall include the following:

(1) In the event the Division of Medical Assistance determines a cost report does not meet the requirement of the Division of Medical Assistance during a detailed review, the provider shall have 30 days from the date of said notification to submit a revised cost report or additional data. Such revised data or report shall be certified by the provider's executive director or designated officer.

(2) In the event that the provider discovers that a report submitted to the Division of Medical Assistance is incomplete, inaccurate, or incorrect, the provider shall immediately notify the Division of Medical Assistance that such error(s) exist. The provider shall have 30 days from the date of said notification to submit a revised report or additional data. Such data or report shall meet the certification requirements of the report being corrected.

(3) Failure to file the corrected reports on a timely basis in accordance to either Subparagraph (d)(1)or (2) of this Section shall result in the related report being considered not filed and subject to the provisions under this State Plan related to the failure to file said reports. However, the Division of Medical Assistance may grant an extension of time of up to 30 days to file said corrected reports, upon the showing of just cause by the provider in writing.

REQUIREMENTS FOR FINANCIAL RECORDS

.0303 REQUIREMENTS FOR FINANCIAL RECORDS

Each provider shall maintain facility-specific financial records which reflect all expenditures incurred and revenues earned related to its ICF-MR services in the Medicaid Program. In addition, the financial records shall properly and clearly reflect all other sources of funds available to the facility's Medicaid ICF-MR program.

(1) Such financial records shall provide clear and precise justification and support for entries included in the cost report, and included in related budgets.

(2) The financial records shall include at a minimum separate accounts for each type of expense, revenue, and other funding resources included in the annual cost report.

(A) All items on the cost report shall be supported by clear and precise financial records. Cost reports that fail this requirement are deemed to be improperly filed and subject to the provisions under this **plan** related to the failure to file said reports.

(3) Effective July 1, 1993, property ownership and use, housekeeping, and operation and maintenance of plant costs related to day treatment services should be separately accounted for on the provider's books and records. Said costs should be reported separately as direct care costs on the 1994 cost report, consistent with guidelines established by the Division of Medical Assistance.

RATE SETTING METHODS FOR NON-STATE FACILITIES

.0304 RATE SETTING METHOD FOR NON-STATE FACILITIES

(a) A prospective rate shall be determined annually for each non-state facility to be effective for dates of service for a 12 month rate period beginning each July 1. The prospective rate shall be paid to the provider for every Medicaid eligible day during the applicable rate year. The prospective rate may be determined after the effective date and paid retroactively to that date. The prospective rate is based on the base year period to be selected by the state. The prospective rate may be changed due to a rate appeal under Section .0308 of this State Plan or facility reclassification under Paragraph (b) of this Section. Each non-state facility, except those facilities where Paragraph (v) of this Section applies, shall be classified into one of the following groups:

(1) Group 1-Facilities with 32 beds or less.

(2) Group 2-Facilities with more than 32 beds.

(3) Group 3-Facilities with medically fragile clients. For rate reimbursement purposes under this Section medically fragile clients are defined as any individual with complex medical problems who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make them dependent upon 24-hr a day medical/nursing/health supervision or intervention.

(4) Facilities in group 1 or 2 in Subparagraph (a)(1) or (2) of this Section shall be further classified in accordance to the level of disability of the facility's clients, as measured by the Developmental Disabilities Profile (DDP) assessment instrument. A summary of the levels of disability is shown in the following chart:

FACILITY DDP SCORE

Level	Low	High
1	200.00	300.00
2	125.00	199.99
3	100.00	124.99
4	75.00	99.99
5	50.00	74.99

(b) Facilities shall be reclassified into appropriate groups as defined in Paragraph (a) of this Section.

(1) When a facility is reclassified, the rate shall be adjusted retroactively back to the date of the event that caused the reclassification. This adjustment shall give full consideration to any reclassification based on the change in facts or circumstances during the year. Overpayments related to this retroactive rate adjustments shall be repaid to the Medicaid program. Underpayments related to this retroactive rate adjustment shall be paid to the provider.

(2) The provider shall be given the opportunity to appeal the merits of the reclassification of any facility, prior to any decision by the Division of Medical Assistance.

(3) The provider shall be notified in writing 30 days before the implementation of new rates resulting from the reclassification of any facility.

(4) The providers and the Division of Medical Assistance shall make every reasonable effort to ensure that each facility is properly classified for rate setting purposes.

(5) A provider shall file any request for facility reclassification in writing with the Division of Medical Assistance no later than 60 days subsequent to the proposed reclassification effective date.

(6) For facilities certified prior to July 1, 1993, the facility DDP score calculated for fiscal year 1993 shall be used to establish proper classification at July 1, 1995.

(7) For facilities certified after June 30, 1993, the most recent facility DDP score shall be used to establish proper classification.

(8) A facility reclassification review shall use the most current facility DDP score.

(9) A facility's DDP score shall be subject to independent validation by the Division of Medical Assistance.

(10) A new facility that has not had a DDP survey conducted on its clients shall be categorized as a level 2 facility for rate setting purpose, pending completion of the DDP survey. Upon completion of the DDP survey, the facility shall be subject to reclassification and rates shall be adjusted retroactively back to the date of certification. Overpayments related to this retroactive adjustment shall be paid to the Medicaid program. Underpayments related to this retroactive rate adjustment shall be paid to the provider.

(c) Facility rates under this Section shall be established at July 1, 1995, under the following:

(1) For facilities certified prior to July 1, 1993, rates shall be derived from the 1993 cost reports.

(2) For facilities certified during fiscal year 1993-1994, the fiscal year 1994 facility specific cost report shall be used to derive rates.

(3) For facilities certified during fiscal year 1994-1995, the fiscal year 1995 facility specific cost report shall be used to derive rates.

(A) Rates for these facilities shall not be adjusted, except for the impact of inflation under Paragraph (k) of this Section, until the fiscal year 1995 cost report has been properly reviewed. Rates for these facilities shall be adjusted retroactively back to July 1, 1995, once the fiscal year 1995 facility specific cost report has been properly reviewed. Overpayments related to this retroactive rate adjustment shall be repaid to the Medicaid program. Underpayments related to this retroactive rate adjustment shall be paid to the provider.

(4) Facilities with rates established during a rate appeal proceeding with the Division of Medical Assistance during fiscal years 1994 or 1995 shall not have their rates established in accordance with Subparagraph (c)(1), (c)(2), or (c)(3) of this Section.

(A) The rates for these facilities shall remain at the level approved in the rate appeal proceeding adjusted only for inflation, as reflected in Paragraph (k) of this Section.

(d) For facilities certified after June 30, 1993, rates developed from filed cost reports for fiscal years subsequent to 1993 may be retroactively adjusted if there is found to exist more than a two percent difference between the filed per diem cost and either the desk audited or field audited per diem cost for the same reporting period. Rates developed from desk audited cost reports may be retroactively adjusted if there is found to exist more than a two percent difference between the desk audited per diem cost and the field audited per diem cost for the same reporting period. The rate adjustment may be made after written notification to the provider 30 days prior to implementation of the rate adjustment.

(e) Each prospective rate developed in accordance with Subparagraph (c)(1),(c)(2), or (c)(3) of this Section consists of the sum of two components as follows:

(1) Indirect care rate

(2) Direct care rate.

(f) A uniform industry wide indirect care rate shall be established for each facility category shown under Subparagraph (a)(1), (a)(2), or (a)(3) of this Section.

(1) The indirect rate for group 1 facilities is established at the fiftieth percentile of the following costs incurred by all facilities with six beds or less in the group 1 category, except those related by common ownership or control to more than 40 said facilities:

(A) The sum of the cost of property ownership and use (POU), administrative and general (A + G), and operation and maintenance of plant (OMP) as determined by the 1993 base year cost reports.

(2) The indirect rate for group 2 facilities is established at the fiftieth percentile of the costs noted in Part (f)(1)(A) of this Section incurred by the group 2 facilities, as determined by the 1993 base year cost reports.

(3) The indirect rate for group 3 facilities is established at the fiftieth percentile of the costs noted in Part (f)(1)(A) of this Section incurred by the group 3 facilities, as determined by the 1993 base year cost reports.

(4) The Group 1 facilities related by common ownership or control to more than 40 said facilities shall receive the same indirect rate as other Group 1 facilities.

(5) The indirect rates established under Subparagraphs (f)(1), (f)(2), and (f)(3) of this Section shall be reduced as determined based on industry cost analysis by an amount not to exceed four percent to account for expected operating efficiencies.

(6) The category specific indirect rate is established by determining the sum of the POU,

A + G, and OMP costs for each facility, dividing this sum by facility bed days to establish a per day indirect cost for all facilities in this category, arranging the per day indirect cost of all facilities in the category in ascending order, and setting the indirect rate for all related facilities at the indirect per diem cost falling at the fiftieth percentile.

(A) Each facility's percentile is calculated by dividing cumulative bed days, of the current facility and all facilities preceding the current facility in the ranking of all facilities, by total bed days of the industry. Therefore, the per diem cost at the fiftieth percentile represents that the cost of service of fifty percent of the bed days is rendered at or below this cost level.

(g) The facility's direct care rate shall be the lower of actual direct care per diem cost (actual cost divided by total bed days) or the per diem limit, as calculated in paragraph (g)(7).

(1) Direct care costs for facilities certified prior to July 1, 1993, shall be based on direct care costs reflected in the 1993 cost reports.

(2) The direct care costs for all facilities certified on or after July 1, 1993, are based on the first facility specific cost report filed after certification.

(3) Based on said cost report, the direct care cost is equal to the sum of all allowable costs reflected in the ICF-MR cost report cost centers, as included in the ICF-MR format effective July 1, 1993, except for the following indirect cost centers:

(A) Property ownership and use
(B) Operational and maintenance of plant and housekeeping -non-labor
(C) Administrative and general

(4) The fiftieth percentile cost limit shall be reduced by one percent each year, for the four year period beginning July 1, 1996, in order to account for expected operating efficiencies, as determined based on industry cost analysis.

(5) The fiftieth percentile cost limit shall be increased each year by price level changes calculated in accordance with Paragraph (k) of this Section.

(6) A direct care limit is established for each facility classification as established under Paragraph (a) of this section. A facility's classification is based on its size or medically fragile clients, per Subparagraphs (a)(1), (a)(2), and (a)(3), and based on the level of disability of the facility's clients, per Subparagraph (a)(4).

(7) The facility-specific classification, as determined under Paragraph (a) of this section, direct care cost limit is established by determining the sum of the direct costs for each facility, dividing the sum by facility bed days to establish a per day direct care cost of all facilities in the classification, arranging the per day direct care cost of all facilities in the classification in ascending order, and setting the direct care cost limit for all related facilities at the direct care per diem cost falling at the fiftieth percentile.

(A) Each facility's percentile is calculated by dividing cumulative bed days, of the current facility and all facilities preceding the current facility in the ranking of

all facilities, by total bed days for the industry. Therefore, the per diem cost at the fiftieth percentile represents that the cost of service of fifty percent of the bed days is rendered at or below this cost level.

(8) The enhanced rate increase provided effective July 1, 2004, with the implementation of an assessment, will be applied completely to the direct care component of the ICF-MR rate and be settled as such.

(h) The indirect rate shall not be subject to cost settlement.

(1) Costs above the indirect rates shall not be paid to the provider.

(2) Costs savings below the indirect rate shall not be recouped from the provider.

(i) The direct care rate shall be subject to cost settlement, based on the cost report, subject to audit, filed with the Division of Medical Assistance.

(1) Cost above the direct rate shall not be paid to the provider.

(2) Cost savings below the direct rate shall be recouped from the provider.

(j) Facilities with rates established during a rate appeal proceeding with the Division of Medical Assistance during fiscal years 1994 or 1995 may choose to cost settle under the provisions of Paragraphs (h) and (i) of this Section, or under the following procedure:

(1) If, during a cost reporting period, total allowable costs are less than total prospective payments, then a provider may retain one-half of said difference, up to an amount of five dollars ($5.00) per patient day. The balance of unexpended payments shall be refunded to the Division of Medical Assistance. Costs in excess of a facility's total prospective payment rate are not reimbursable.

(2) The facilities subject to the Paragraph shall make the election on cost settlement methodology on or before the filing of the annual cost report with the Division of Medical Assistance.

(3) An election to follow the cost settlement procedures of Paragraph (h) and (i) of this Section shall be irrevocable.

(4) Rates established for these facilities during future rate appeal proceedings shall be subject to the cost settlement procedures of Paragraphs (h) and (i) of this Section.

(k) To compute each facility's current prospective rate, the direct and indirect rates established by Paragraphs (f) and (g) of this Section shall be adjusted for price level changes since the base year. No inflation factor for any provider shall exceed the maximum amount permitted for that provider by federal or state law and regulations. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 1 to the 4.19-D section of the state plan.

(1) Price level adjustment factors are computed using aggregate costs in the following manners:

(A) Costs shall be separated into three groups:

(i) Labor,

(ii) Non-Labor,

(iii) Fixed.

(B) The relative weight of each cost group is calculated to the second decimal point by dividing the total costs of each group (labor, nonlabor, and fixed) by the total cost of the three categories.

(C) Price level adjustment factors for each cost group shall be established as follows:

(i) Labor. The percentage change for labor costs is based on the projected average hourly wage of North Carolina service workers. Salaries for all personnel shall be limited to levels of comparable positions in state owned facilities or levels specified by the Division of Medical Assistance.

(ii) Nonlabor. The percentage change for nonlabor costs is based on the projected annual change in the implicit price deflator for the Gross National Product as provided by the North Carolina Office of State Budget and Management.

(iii) Fixed. No price level adjustment shall be made for this category.

(D) The weights computed in Part (k)(1)(B) of this Section shall be multiplied by the rates computed in Part (k)(1)(C) of this Section. These weighted rates shall be added to obtain the composite inflation rate to be applied to both the direct and indirect rates.

(2) If necessary, the Division of Medical Assistance shall adjust the annual inflation factor or rates in order to prevent payment rates from exceeding upper payment limits established by Federal Regulations. Effective July 1, 2001, the price level adjustment factors calculated in (k) (1) (D) of this Section shall not exceed that approved by the North Carolina General Assembly.

(l) Effective July 1, 1995, any rate reductions resulting from the State Plan Amendment 95-03 shall be implemented based on the following deferral methodology:

(1) Rates shall be reduced for the excess of current rates over base year costs plus inflation.

(2) Rates shall be reduced a maximum of 50 percent of the fiscal 1996 inflation rate for the excess of actual costs over applicable cost limits. This reduction shall result in the facility receiving at a minimum 50 percent of the 1996 inflation rate. Any excess reduction shall be carried forward to future years.

(3) Total reduction in future years related to the excess reduction carried forward from Subparagraph (1)(2) of this Section, shall not exceed the annual rate of inflation. This reduction shall result in the facility receiving at minimum the rate established in Paragraph (1)(2) of this Section. Any excess reduction shall be carried forward to future years, until the established rate equals that generated by Paragraphs (f),(g), and (k) of this Section.

(4) Rates calculated based on Subparagraphs (1)(2) and (3) of this Section shall be cost settled based on the provisions of Subparagraphs (j)(l) of this Section until the fiscal year that the facility receives full price level increase under Paragraph (k) of this Section.

(A) A provider may make an irrevocable election to cost settle under the provisions of Paragraphs (h) and (i) of this Section during the deferral period.

(B) Once the rates calculated based on Subparagraphs (1)(2) and (3) of this Section reach the fiscal year that the facility receives the full price level increase under Paragraph (k), then said fiscal year's rates shall be cost settled based on Paragraphs (h) and (i) of this Section.

(C) Chain providers are allowed to file combined cost reports, for cost settlement purposes, for facilities that use the same cost settlement methodology and have the same uniform rate.

(D) A provider may request from the Division of Medical Assistance permission to continue cost settlement under Subparagraph (j)(1) of this Section after the deferral period expires. Said request shall be made each year, 30 days prior to the

cost report due date.

(m) The initial rate for facilities that have been awarded a Certificate of Need is established at the lower of the fair and reasonable costs in the provider's budget, as determined by the Division of Medical Assistance, or the projected costs in the provider's Certificate of Need application, adjusted from the projected opening date in the Certificate of Need application to the current rate period in which the facility is certified based on the price level change methodology set forth in Paragraph (k) of this Section, or the rate currently paid to the owning provider, if the provider currently has an approved chain rate for facilities in the related facility category. The rate may be rebased to the actual cost incurred in the first full year of normal operations in the year an audit of the first year of normal operation is completed.

(1) In the event of a change in ownership, the new owner receives no more than the rate of payment assigned to the previous owner.

(2) Except in cases wherein the provider has failed to file supporting information as requested by the Division of Medical Assistance, initial rates shall be granted to new enrolled facilities no later than 60 days from the provider's filing of properly prepared budgets and supporting information.

(3) The initial rate for a new facility shall be applicable to all dates of service commencing with the date the facility is certified by the Medicaid Program.

(4) The initial rate for a new facility shall not be entered into the Medicaid payment system until the facility is properly enrolled in the Medicaid program and a Medicaid identification number has been assigned to the facility by the Division of Medical Assistance.

(n) A provider with more than one facility may be allowed to recover costs through a combined uniform rate for all facilities.

(1) Combined uniform rates for chain providers shall be approved upon written request from the provider and after review by the Division of Medical Assistance.

(2) In determining a combined uniform rate for a chain provider, the weighted average chain rate is calculated as follows:

(A) For each facility, multiply the facility-specific rate, calculated in accordance with paragraphs (f) and (g) and all other provisions of this plan, by facility-specific number of beds.

(B) Add products of calculations in Item A.

(C) Divide sum of Item B by total number of beds of all facilities included in item A. This is the weighted average chain rate.

(3) A chain provider with facility(s) that fall under Paragraphs (h) and (i) of this section and with facility(s) that fall under Subparagraph (1)(4) of this Section may elect to include **all** the facilities in a combined cost report and elect to cost settle under either Paragraphs (h) and (i) or Subparagraph (1)(4). The cost settlement selection shall be made each year, 30 days prior to the cost report due date.

(o) Each out-of-state provider shall be reimbursed at the lower of the applicable North Carolina rate,.

as established by this plan for in-state facilities, or the provider's per diem rate as established by the state in which the provider is located. An out-of-state provider is defined as a provider that is enrolled in the Medicaid program of another state and provides ICF-MR services to a North Carolina Medicaid client in a facility located in the state of enrollment. Rates for out-of-state providers are not subject to cost settlement.

(p) Under no circumstances shall the Medicaid per diem rate exceed the private pay rate of a facility.

(q) Should the Division of Medical Assistance be unable to establish a rate for a facility, based on this Section and the applicable facts known, the Division of Medical Assistance may approve an interim rate.

(1) The interim rate shall not exceed the rate cap established under this Section for the applicable facility group.

(2) The interim rate shall be replaced by a permanent rate, effective retroactive to the commencement of the interim rate, by the Division of Medical Assistance, upon the determination of said rate based on this Section and the applicable facts.

(3) The provider shall repay to the Division of Medical Assistance any overpayment resulting from the interim rate exceeding the subsequent permanent rate.

(r) In addition to the prospective per diem rate developed under this Section, effective July 1, 1992, an interim payment add on shall be applied to the total rate to cover the estimated cost required under Title 29, Part 1910, Subpart 2, Section 1910.1030 of the Code of Federal Regulations. The interim payment add-on is based on a cost model developed from an analysis of the incremental costs associated with this program. Total incremental costs from the cost model divided by total bed days yields the interim per diem add-on. The interim rate shall be subject to final settlement reconciliation with reasonable cost to meet the requirements of Section 1910.1030. The final settlement reconciliation shall be effectuated during the annual cost report settlement process. An interim rate add-on to the prospective shall be allowed, subject to final settlement reconciliation, in subsequent rate periods until cost history is available to include the cost of meeting the requirements of Section 1910.1030 in the prospective rate. This interim add-on shall be removed, upon 10 days written notice to providers, should it be determined by appropriate authorities that the requirements under Title 29, Part 1910, Subpart 2, Section 1910.1030 of the Code of Federal Regulations do not apply to ICF-MR facilities.

(s) All rates, except those noted otherwise in this Section, approved under this Section are considered to be permanent.

(t) In the event that the rate for a facility cannot be developed so that it shall be effective on the first day of the rate period, due to the provider not submitting the required reports by the due date, the average rate for facilities in the same facility group, or the facility's current rate, whichever is lower, shall be in effect until such time as the Division of Medical Assistance can develop a new rate.

(u) When the Division of Medical Assistance develops a new rate for a facility for which a rate was paid in accordance with Paragraph (t) of this Section, the rate developed shall be effective on the first day of the second month following the receipt by the Division of Medical Assistance of the required reports. The Division of Medical Assistance may, upon its own motion or upon application and just cause shown by the provider, within 60 days subsequent to submission of the delinquent report, make the rate retroactive to the beginning of the rate period in question. Any overpayment to the provider resulting from this temporary rate being greater than final approved prospective rate for the facility shall be repaid to the Medicaid Program.

(v) ICF-MR facilities meeting the requirements of the North Carolina Division of Facility Services as a facility affiliated with one or more of the four medical schools in the state providing services on a statewide basis to children with various developmental disabilities who are in need of long-term high acuity nursing care, dependent upon high technology machines (i.e. ventilators and other supportive breathing apparatus), monitors and feeding techniques shall have a prospective payment rate that approximates cost of care. The payment rate may be reviewed periodically, no more than quarterly, to assure proper payment. The prospective payment rate is based on the Division of Medical Assistance's review of the facilities' budgets, cost reports, and other appropriate data, including budgeted costs and bed days. These facilities are paid an interim per diem which is calculated by divided the facility's budgeted costs by the facility's budgeted bed days. A cost settlement at the completion of the fiscal period year end is required. Payments in excess of cost are to be returned to the Division of Medical Assistance.

(A) Upon proper notice and review, the Division of Medical Assistance may establish a prospective rate for said facilities, subject to cost settlement procedures of paragraphs (h) and (i) of this Section.

(w) A special payment in addition to the prospective rate shall be made in the year that any provider changes from the cash basis to the accrual basis of accounting for vacation leave costs. The amount of this payment shall be determined in accordance with Title XVIII allowable cost principles and shall equal the Medicaid share of the vacation accrual that is charged in the year of the change including the cost of vacation leave earned for that year and all previous years less vacation leave used or expended over the same time period and vacation leave accrued prior to the date of certification. The payment shall be made as a lump sum payment that represents the total amount due for the entire fiscal year. An interim payment may be made based on an estimate of the cost of the vacation accrual. The payment shall be adjusted to actual cost after audit.

(x) The annual prospective rate, effective beginning each July 1, for facilities that commenced operations under the Medicaid Program subsequent to the base year used to establish rates, and therefore did not file a cost report for the base year, shall be based on the facility's initial rate, established in accordance with Paragraph (m) of this Section, and the applicable price level changes, in accordance with Paragraph (1) of this Section.

MEDICAL ASSISTANCE
State: North Carolina

PROSPECTIVE REIMBURSEMENT PLAN FOR ICF-MR FACILITIES
PAYMENT FOR SERVICES

(y) Effective for fiscal year beginning on or after fiscal year 1998, installation cost of Fire Sprinkler Systems in an ICF-MR Facility shall be reimbursed in the following manner.

(1) Upon receipt of the documentation listed in Parts (A) through (E) of this Subparagraph, the Division of Medical Assistance shall reimburse directly to the provider ninety percent of the verified cost.
   (A) All related invoices.
   (B) Verification from the Division of Facility Services that the Sprinkler System is needed.
   (C) Statement from appropriate authorities that the Sprinkler System has been installed.
   (D) Three bids to install the system.
   (E) Prior approval from the Division of Medical Assistance for any installation projected to cost more than $25,000.

(2) The unreimbursed installation cost shall be reimbursed after audit through the annual Cost Settlement Process. This portion shall be offset by profits, after taking into consideration any indirect profits and direct losses. Any overpayments determined after audit shall be returned to the program by the provider through the annual cost settlement process.

(3) The installation of the Sprinkler System is Subject to Prudent Buyer Standards contained in the HCFA-15.

(4) The Sprinkler System's installation costs shall be properly recorded on the provider's ICF-MR Cost Report.

(z) ICF-MR Facility Assessment. An adjustment to the ICF-MR Facility payment rate calculated in accordance with section .0304 (f) and (g) is established, effective July 1, 2004, to reimburse Medicaid participating facilities for the provider's assessment costs that are incurred for the care of NC Medicaid residents. No adjustment will be made for the provider's assessment costs that are incurred for the care of private paying residents or others who are not Medicaid eligible.

Allowable Costs

.0305 Allowable Costs

(a) To be considered allowable, costs shall not exceed fair and reasonable levels as determined by the Division of Medical Assistance, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, and shall be required to provide necessary client care under the Medicaid Program.

(1) The cost of goods or services sold to non-Medicaid clients shall be excluded in determining the allowable client related expenses reimbursable under the Medicaid program. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(2) Examples of sources of such income items include, but are not limited to:

(A) supplies and drugs sold by the facility for use by nonresidents,
(B) telephone and telegraph services for which a charge is made,
(C) discount on purchases,
(D) employee rental of living quarters,
(E) cafeterias,
(F) meals provided to staff or a client’s guest for which there is a charge,
(G) lease of office and other space by concessionaires providing services not related to intermediate care facility services,
(H) interest income except for income earned on qualified pension funds and income from gifts or grants which are donor restricted.

(b) Except where specific Sections concerning allowability of costs are stated herein, the Division of Medical Assistance shall use as its major determining factor in deciding on the allowability of costs, the Medicare Provider Reimbursement Manual, published by the U.S. Department of Health and Human Services’ Health Care Financing Administration (HCFA). Where specific Sections stated herein or in HCFA-15 are silent concerning the allowability of costs, the Division of Medical Assistance shall determine allowability of costs based on a case specific review taking into consideration the reasonableness of said costs and their relationship to client care and generally accepted accounting principles, consistent with this State Plan.

(c) As determined by the Division of Medical Assistance, expenses or portion of expenses reported by an individual facility that are not reasonably related to the efficient and economical provision of care in accordance to the requirements of this Plan, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, because of either the nature or amount of the item, shall not be allowed.

(1) Reasonable compensation, as determined by Division of Medical Assistance, of individuals employed by a provider is an allowable cost, provided such employee are engaged in client related functions and that the compensation is reasonable in light of industry historical data. The historical data shall include, but not be limited to, salary levels for similar services in the same market in which the facility is located.

(2) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the Division of Medical Assistance. Payroll records shall indicate each employee's classification, hours worked, rate of pay, and the functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one cost center, the provider shall maintain periodic time studies in order to allocate salary and wage costs to the appropriate cost centers as determined by the Division of Medical Assistance. These periodic time studies shall be maintained in accordance with the Medicare Provider Reimbursement Manual.

(3) The Division of Medical Assistance shall not reimburse costs related to excess staff, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances.

(4) Compensation for owners is allowable only for duties which the owner is qualified to render and that otherwise would require the employment of another individual in the provision of ICF-MR related services. Said compensation shall be limited to a reasonable amount, as determined by the Division of Medical Assistance, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, not to exceed that paid in the local market place for similar type duties. Compensation for owners is not allowable where the services are not related to the provision of ICF-MR related services.

(d) As determined by the Division of Medical Assistance, costs which are not properly related to client care or treatment, and which principally afford diversion, entertainment or amusement to owners, operators, or employees of the facility shall not be allowed.

(e) Costs for any interest expense related to funding expenses in excess of a fair and reasonable amount based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, or penalty imposed by governmental agencies or courts and the costs of insurance policies obtained solely to insure against such penalty, shall not be allowed.

(f) Costs of contributions or other payments to political parties, candidates or organizations shall not be allowed.

(g) As determined by the Division of Medical Assistance, only that portion of dues paid to any professional association which has been demonstrated to be reasonable in amount and attributable to Medicaid Program related expenditures other than for lobbying or political contributions shall be allowed. The burden of proof shall be on the provider to justify the inclusion of any professional association dues. Association budgets may be considered in determining said justification. At a minimum, the preponderance of evidence must show a benefit to the providers' operations from membership in the association.

(h) Any cost of the sale, purchase, alteration, construction, rehabilitation or renovation of a physical plant or interest in real property shall be considered allowable up to the amount approved by the Division of Medical Assistance. Cost is limited by the applicable provisions of paragraphs (i) and (1) of this Section. Cost is allowable only to the extent it is necessary for the provision of adequate client care under this Plan, as determined by the Department of Health and Human Resources.

Cost, and the associated financing, equal to or greater than ten thousand ($10,000) related to existing facilities or the construction of replacement facilities is subject to prior Division of Medical Assistance approval. Providers shall not incur said costs in a piece meal fashion in order to avoid the ten thousand ($10,000) limit. Failure to acquire prior approval shall result in the disallowance of said cost from Medicaid reimbursement, unless failure to acquire prior approval was caused by reasons beyond the control of the provider.

(1) The provider shall file the necessary documentation to support the justification for the proposed expenditure and related financing with the Division of Medical Assistance no later than ninety (90) days prior to the proposed transaction's commencement date.

(2) The Division of Medicaid Assistance shall render a decision in writing to the provider on the propriety of the proposed transaction no later than thirty (30) days prior to the proposed transaction's commencement date.

(3) The time requirements of Subparagraphs (h)(1) and (2) of this Section shall be altered, by the Division of Medical Assistance with just cause shown that failure to make timely filing was caused by reasons beyond the control of the provider.

(4) For any transaction resulting in a change of ownership, the valuation of the asset shall be limited to the lesser of the allowable acquisition cost of the assets to the first owner of record who has received Medicaid payment for said asset, less any accumulated depreciation, plus any allowable improvements, or the acquisition cost of the asset to the new owner. Payment of rent by the Medicaid enrolled provider to the lessor of a facility shall constitute Medicaid payments under this Plan.

(5) Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under Medicaid, shall not be allowable for reimbursement.

(6) An exception may be applied by the Division of Medical Assistance to the requirements of either Subparagraph (h)(4) or (5) of this Section, if it can be proven that the change in ownership shall result in increasing the level of care provided to the facility's clients up to the level required by the Division of Facility Services.

(A) In order to meet this exception, it shall be proven that the previous facility owner was not providing, and was incapable of providing, adequate client service, as determined by the Department of Human Resources.

(B) The burden of proof in supporting this exception is on the provider. The provider shall request, in writing, consideration of this exception from the Division of Medical Assistance.

(C) Consideration of this exception may result in the Division of Medical Assistance allowing some or all of the costs in Subparagraph (h)(5) for Medicaid reimbursement.

(D) Consideration of this exception may result in the Division of Medical Assistance allowing a substitute valuation as determined on a case by case basis and based on the preponderance of evidence for the transferred property under Subparagraph (h)(4) that is greater than the limit noted, but in no instance greater than the acquisition cost of the assets to the new owner.

(i) A facility's annual rental payments for real property may be considered an allowable cost subject to the following conditions and the limits included in Paragraph (i)(1) of this Section:

(1) The lease is reviewed by and acceptable to the Division of Medical Assistance.

(A) The lease shall not be acceptable if the associated asset(s) are not needed for client care as determined by the Division of Medical Assistance.

(B) The lease shall not be acceptable if alternate means of financing is deemed available and more economical. In making this determination all aspects of the economic impact of the lease shall be examined including length of lease, the cost of the asset to the owner, and the incremental rate of return provided to the lessor. In addition, the leasee's incremental implicit rate of interest and financial position shall be considered.

(C) The test of reasonableness shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

(D) Absent clear justification to the contrary, material capital improvements to leased property that are necessary to maintain the asset in its ordinary state of usability at the commencement of the lease, shall be the responsibility of the lessor. Examples of said costs are roof or utility service replacement due to reasons beyond the prudent control of the lessee.

(E) Effective July 1, 1993, requests for prior approval of new leases and lease renewals must be submitted whenever possible at least 120 days prior to the last date for the exercise of the lease or lease renewal option. HUD leases with individual ICF-MR clients are not subject to this requirement.

(F) Failure to acquire prior approval of leases and lease renewals shall result in the disallowance of said cost from Medicaid reimbursement, unless failure to acquire prior approval was caused by reasons beyond the control of the provider.

(2) The lease shall be considered an arm's-length transaction in accordance with Medicare Principles of Reimbursement as contained in the HCFA-15. Leases failing the HCFA-15 arm's-length transaction test shall be reimbursed at the leased asset's reasonable cost of depreciation, interest, if any, and other related expenses, including but not limited to reasonable maintenance costs, as determined by the Division of Medical Assistance. It is the responsibility of the provider to maintain auditable records to document these ownership costs to the Division of Medical Assistance or its designated contract auditors. Undocumented costs will be disallowed.

(3) The lease amount is comparable to similar leases for properties with similar functions in the same geographical area.

(4) The lease agreement between unrelated parties shall include the provision that the amount of rental to be paid by the lessee to the lessor shall not, in any event, exceed the amount approved by the Division of Medical Assistance.

(j) Depreciation shall be an allowable cost when based upon factors of historical costs and useful life. Depreciation shall be subject to the provisions of this Paragraph and Subparagraph (j)(1) of this Section. For the purpose of this Section:

(1) Unless an exception is made by the Division of Medical Assistance, the useful life shall be the higher of the reported useful life or that from the Estimated Useful Lives of Depreciable Hospital Assets (1988 edition**).** A copy of the Useful Lives of Depreciable Hospital Assets can be obtained by writing to the American Hospital Association, 840 Lake Shore Drive, Chicago, Illinois, 60611. In certain instances, a useful life that is based upon historical experience as shown by documentary evidence and approved by the Division of Medical Assistance may be allowed. Should the provider desire a depreciation rate different from that based on the general rule in Subparagraph (j)(1) of this Section, then said provider shall make the request in writing to the Division of Medical Assistance. Upon review and analysis, the Division of Medical Assistance shall make **a** determination in writing as to the reasonableness of said request.

(2) The depreciation method used shall be the straight-line method.

(3) Unless an exception is granted by the Division of Medical Assistance, depreciated rates shall be applied uniformly and consistently in accordance with this State Plan and generally accepted accounting principles. Should the provider discover that depreciation has been improperly recorded in prior years, then the provider shall within 30 days report the error to the Division of Medical Assistance. The impact of the error on the provider’s rate shall be fully considered by the Division of Medical Assistance and a rate adjustment may be made, with due cause shown. Failure to record depreciation properly shall result in disallowance for Medicaid reimbursement purposes, unless failure to comply with this provision was caused by reasons beyond the control of the provider.

(4) Depreciation paid to the provider by the Medicaid Program shall be prudently used by said provider to meet the financial requirements of providing adequate service to the ICF-MR clients.

(A) Payment to related parties for costs disallowed by this plan for Medicaid reimbursement may be considered imprudent use of depreciation reimbursement.

(B) Imprudent use of Medicaid reimbursement of depreciation may result in the provider being required by the Division of Medical Assistance to fund the depreciation through a qualified independent entity or disallowance of depreciation for Medicaid reimbursement

(5) In order to substantiate depreciation expense for Medicaid reimbursement purposes, the property records shall include, at a minimum, all of the following, for assets purchased on or after July 1, 1993:

(A) The depreciation method used,

(B) A description of the asset,

(C) The date the asset was acquired,
(D) The cost of the asset,
(E) The salvage value of the asset,
(F) The depreciation cost,
(G) The estimated useful life of the asset,
(H) The depreciation expense each year,
(I) The accumulated depreciation.

(6) The recovery of losses associated with the disposal or abandonment of assets used to provide necessary services to the Medicaid program shall be determined on a case-by-case basis. Requests for recovery shall be made in writing and are subject to prior Division of Medical Assistance approval. Failure to acquire approval shall result in the disallowance of said costs, unless failure to acquire approval was caused by reasons beyond the control of the provider.

(7) The treatment of gains associated with the disposal of assets used to provide necessary services to the Medicaid program shall be based on this plan and the Medicare Principles of Reimbursement as contained in the HCFA-15.

(k) Interest cost may be considered an allowable cost subject to the following conditions, and the limits included in paragraph (k)(1) of this section:

(1) Interest for capital indebtedness, where the interest expense results from the initial financing of the capital indebtedness and the capital indebtedness represents all or part of the current Division of Medical Assistance approved value of the property. The property shall be necessary for the provision of adequate service, as determined by the Department of Human Resources, to the clients of the ICF-MR facility. The financing shall be prudently incurred, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances.

(2) The interest rate shall not be in excess of the amount a prudent borrower would pay at the time the loan was incurred. In determining the reasonableness of the interest rate, all associated factors at the time the loan was incurred shall be considered, including, but not limited to the following:
(A) Current market rates of interest in the economy.
(B) Industry specific rates of interest.
(C) Provider specific financial position.

(3) The loan agreement shall be entered into between parties not related through control, ownership, affiliation, or personal relationship as defined in the Medicare Principles of Reimbursement as reflected in the HCFA-15, unless this provision is waived in writing by the Division of Medical Assistance. Such waiver shall be based on, but not limited to, a demonstration of need for the indebtedness and cost savings resulting from the transaction. The burden of proof shall be on the provider to provide proper support and justification for such waiver to the Division of Medical Assistance. Loans from a related party must be clearly identified and reported separately on the annual cost report.

(4) Interest expense on working capital indebtedness is allowable, subject to the Division of Medical Assistance's approved level of working capital, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances.
   (A) Interest on excess working capital is specifically denied.
   (B) Working capital shall be established at the level necessary to support the facility's operations, after taking into full consideration the lead/lag impact of the facility's expenditures and reimbursements.

(5) Interest expense for capital indebtedness where the interest expense results from the refinancing of the capital indebtedness, and the refinancing has the prior approval of the Division of Medical Assistance, shall be allowed in that amount associated with the outstanding principal prior to refinancing. Interest costs may be allowed in excess of the amount associated with the outstanding principal balance prior to refinancing, if the purpose of the debt is to acquire assets to be used for care of persons served by the facility and all other applicable requirements of this plan are met. Interest expense resulting from the inclusion of the closing costs, such as, but not limited to, attorney's fees, recording costs and points in the refinancing transaction shall be considered allowable.
   (A) The provider should file all necessary documents supporting its request for refinancing prior approval to the Division of Medical Assistance no later than 120 days prior to the proposed refinancing date.
   (B) The Division of Medical Assistance shall render a decision regarding the prior approval request no later than thirty (30) days prior to the proposed refinancing date.
   (C) Based upon just cause shown, the Division of Medical Assistance may waive the time requirements included in parts (k)(5)(A) and (B) of this Section, but in all cases there shall be enough time allowed to evaluate the proposed refinancing.

(6) In all cases, in order for the interest expense to be allowable it shall be necessary to satisfy a financial need related to the adequate provision of recipient care, as determined by the Division of Medical Assistance. Loans which result in excess funds or investments are not considered necessary.

(7) Interest expense shall not be allowable when related to loans that failed to receive prior approval, as required, from the Division of Medical Assistance, unless failure to acquire prior approval was caused by reasons beyond the control of the provider.

(8) In no event shall interest expense be allowed on a facility's cost that is deemed to be excessive.

(l) The annual capital cost or lease expense limitations shall apply:

(1) To all facilities with twenty-one (21) or more beds and to facilities consisting of multiple detached buildings in which at least one contains nine (9) certified beds. The facilities covered by this limit shall have been awarded a Certificate of Need before January 1, 1993. The annual capital cost or lease expense limit shall be the lesser of actual cost or

the sum of (A) and (B) as follows:

(A) The annual depreciation on plant and fixed equipment that would be computed on assets equal to thirty thousand dollars ($30,000) per bed (capital recovery base) during fiscal year 1982-83 adjusted for changes in the following cost indexes:

(i) For the period after 1982-83 and through the period 1991-92 the capital recovery base shall be adjusted for changes in the Dodge Building Cost Index of North Carolina Cities.

(ii) For the period beginning July 1, 1992 the capital recovery base shall be adjusted for changes in the implicit price deflator for residential structures as provided by the Office of State Budget and Management. Depreciation expense shall be computed using the straight line method of depreciation and the useful life standards established by the American Hospital Association.

(B) An interest allowance equal to ten percent (10%) of the capital recovery base used to compute annual depreciation on plant and fixed equipment.

(C) This annual capital cost or lease expense limit does not apply to leases in effect prior to August 3, 1983.

(2) To all facilities that have been awarded a Certificate of Need on or after January 1, 1993, the annual capital cost or lease expense shall be limited to the lesser of actual cost or the fair and reasonable depreciation and interest at the time of certification and enrollment into the Medicaid program.

(A) Depreciation expense shall be computed using the straight line method of depreciation and the useful life standards established by the American Hospital Association.

(B) Interest expense is computed using a ten percent (10%) rate of interest.

(C) The capital recovery base is established as thirty thousand dollars ($30,000) of plant and fixed equipment assets per bed during the fiscal year 1982-83 adjusted for the changes in the cost indexes contained in subparagraphs (l)(1)(A),(i) and (ii) of this Section.

(D) Recovery of the cost of material additions to plant and fixed equipment subsequent to certification and enrollment in the Medicaid program shall be subject to review on a case by case basis, consistent with the provisions of this State Plan.

(E) The capital cost or lease expense limitation should be considered the absolute maximum allowable for Medicaid reimbursement. In evaluating the reasonableness of a particular facility's capital cost or lease expense, regional costs of land and construction should be considered. In cases where the reasonable regional costs are less than those derived from subparagraph (1)(2)(C) of this Section, above, then the regional costs should be used in determining the appropriate capital cost or lease expense limitations.

(i) In determining fair and reasonable facility cost, the average cost of similar construction in the same local area should be used. This test of reasonableness should be applied to all components of the facility's construction cost, including square footage and per unit costs.

(ii) Absent strong, clear justification to the contrary, no six (6) bed facility shall be allowed to recover capital cost and lease expense related to square footage in excess of 3200 square feet.

(3) Failure to provide supporting evidence of actual facility cost incurred shall result in disallowance of said cost unless failure to provide the information was caused by reasons beyond the control of the providers.

(m) For providers whose annual reimbursement from the Medicaid program exceeds one million dollars ($1,000,000), all contracts with related parties as defined in the Medicare Principles of Reimbursement as reflected in the HCFA-15, in the amount of ten thousands dollars ($10,000) or more shall receive prior approval from the Division of Medical Assistance.

(1) Failure to file said contracts with the Division of Medical Assistance shall result in disallowance of the related cost from Medicaid reimbursement, unless failure to file said contracts was caused by reasons beyond the control of the provider.

(2) The contracts shall be filed with the Division of Medical Assistance ninety (90) days prior to the effective date of said contracts.

(n) "Donations," for purposes of this Section, shall mean grants, gifts, or income from endowments, cash or otherwise, given to a provider by a donor. "Unrestricted donations" shall mean donations given without restrictions by the donor as to their use. "Restricted donations" shall mean donations which the donor has specified the provider must use only for a specific purpose or within a specific time period designated by the donor, and shall not mean donations which the provider has restricted or designated for use for a specific purpose or within a specific time period.

(1) Providers are encouraged to raise donations to support their operations. Absent evidence to the contrary, donations shall be presumed used to support Medicaid program costs.

(2) Restricted donations for which the donor has specified a time period for the use of the donation shall be deemed to have been applied to support the provider's costs within the donor-specified time period.

(3) Unrestricted donations or restricted donations without a donor-specified time period for use shall be presumed to have been applied to support the provider's costs in the year in which such donations were acquired, unless the provider demonstrates otherwise by, without

limitation, the following factors:

(A) The documented decision of the Board of Directors or management as to the time for use of the funds.

(B) The provider's supporting documentation, including general ledger accounting, regarding the time period in which the donations were used.

(4) In determining whether non-Medicaid program costs are supported by donations, the following factors, without limitation, shall be considered:

(A) The decision of the provider's Board of Directors or management regarding the use of unrestricted donations.

(B) The donor's specifications, in cases of restricted donations.

(C) The provider's supporting documentation, including general ledger accounting, regarding use of donations.

(5) Costs included in the provider's Medicaid cost report which are supported by donations shall be reduced by the net value of the donations.

(A) The "net value" of a donation shall mean the fair market value of the donation minus the provider's reasonable costs of acquiring the donation.

(B) Reasonable costs of acquiring donations are those costs incurred by an economic and efficient provider.

(C) The provider's general ledger and supporting documents shall support the provider's reported cost of acquiring donations.

(D) The net value of a provider's donations shall not be less than zero.

(o) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Allocation of central office costs shall be reasonable and conform to the directives of the Division of Medical Assistance and generally accepted accounting principles. Such costs are allowable only to the extent that the central office is providing services related to client care and the provider can demonstrate that the central office costs improved efficiency, economy, or quality of recipient care. The burden of demonstrating that costs are client related lies with the provider.

(1) If a provider has business enterprises other than those reimbursed by Medicaid, then the revenues, expenses, statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid.

(2) If an audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the co-mingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance as of the earlier of the commencement of the rate period related to the co-mingled costs, or the commencement of the co-mingling of said costs.

(3) After the co-mingled costs have been satisfactorily allocated and reported to the Division of Medical Assistance, and based on a showing by the provider that procedures have been implemented to insure that the co-mingling will not occur in the future, the Division of Medical Assistance shall retroactively adjust the facility's rate.

(4) Central office costs are generally charged to the Administrative and General cost center. In some cases, however, personnel costs which are direct patient care oriented may be allocated to direct care cost centers if time records are maintained to document the performance of direct patient care services. No home office overhead may be so allocated. The basis of this allocation among facilities participating in the North Carolina Medicaid program may be:

(A) specific time records of work performed at each facility,

(B) client days in each facility to which the costs apply relative to the total client days in all the facilities to which the costs apply, or

(C) any other allocation method approved by the Division of Medical Assistance, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence of a case-by-case review.

(p) All criteria and limitations used by the Division of Medical Assistance to subject individual provider cost data to tests of reasonableness shall be based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances. In determining reasonableness of costs, the Division of Medical Assistance may compare major cost centers or total costs of similar providers and may request satisfactory documentation from providers whose cost do not appear to be reasonable. Similar providers are those with like levels of client care, size, and geographic location.

(q) Start-up costs are costs incurred by an ICF-MR facility while preparing to provide services at said facility. They include the cost incurred by providers to provide services at the level necessary to obtain certification less any revenue or grants related to start-up. The North Carolina Medicaid Program shall reimburse these start-up costs up to a maximum equal to the facility's initial rate, determined under Section .0304 (m), times certified beds times 120 days.

(1) Effective for all facilities whose Certificate of Need was granted on or after January 1, 1993, start-up costs shall be amortized over a thirty-six (36) month period and shall be reported as administrative and general in the cost report. No advance of these start-up costs shall be made. These costs shall not be included in calculating the facility's total AG/OMP costs for rate setting purposes in accordance with this Plan. These costs

shall be paid manually outside of the per diem rate, with equalized payments made each month over the 36 month amortization period.

(2) Effective for all facilities whose CON was granted prior to January 1, 1993, the start-up reimbursement shall be made in addition to the facility's per diem rate. No advance of start-up funds shall be made prior to the submission of the start-up cost report. An interim payment not to exceed eighty percent (80%) of the allowable start-up costs can be made at the written request of a provider after a start-up cost report has been filed. The remaining balance of appropriately incurred start-up costs shall be paid after the desk audit of the start-up costs report has been completed. These start-up cost payments are made manually outside of the per diem rate. Any balance due to the Medicaid program shall be repaid promptly.

(3) A start-up cost report shall be filed with the Division of Medical Assistance. A copy of the start-up cost report shall be provided by the Division of Medical Assistance to each newly Medicaid certified facility.
- (A) A start up cost report shall be filed with the Division of Medical Assistance Audit Section.
- (B) Schedule E of the start up cost report shall be filed with the Division of Medical Assistance's Rate Setting Section.

(4) Allowable start-up costs may include, but not be limited to:
- (A) personal services expenses,
- (B) utility expenses,
- (C) property taxes,
- (D) insurance expenses,
- (E) employee training expenses,
- (F) housekeeping expenses,
- (G) repair and maintenance expenses,
- (H) administrative expenses.

(5) All costs that are properly identifiable as organization costs shall be classified as such and excluded from start-up costs.

(6) Costs related to increasing bed capacity in an existing facility shall not be treated as start-up costs.

(r) Only that portion of management fees that is directly related to client care and is not otherwise functionally covered by the current staffing pattern is allowable in the calculation of a facility's actual, allowable, and reasonable costs. Management fees on a per diem basis shall be limited to seven (7) percent of the maximum intermediate care rate for nursing facilities enrolled in the Medicaid Program. Management fees shall be charged to the Administrative and General Cost Center. A portion of a management fee may be allocated to a direct patient care cost center if time records are maintained to document the performance of direct care services.. The amount so allocated may be equal only to the salary and fringe benefits of persons who are performing direct patient care services while

employed by the management company. Records to support these costs shall be made available to staff of the Division of Medical Assistance. The basis of this allocation among facilities participating in the North Carolina Medicaid program may be:

(1) specific time records of work performed at each facility, or
(2) client days in each facility to which the costs apply relative to the total client days in all facilities to which the cost apply.

(s) The following costs are considered non-allowable facility costs because they are not related to client care or are specifically disallowed under the North Carolina State Plan:

(1) bad depts;
(2) advertising, except personnel want ads, and one line yellow page (indicating facility address);
(3) charity, courtesy allowances, discounts, refunds, rebates and other similar items granted by the provider;
(4) life insurance (except for employee group plans and reasonable key man life insurance premiums required by financial institutions in an outstanding loan agreement);
(5) prescription drugs and insulin (available to recipients under the State Medicaid Drug Program);
(6) vending machine expenses;
(7) state or federal corporate income taxes, plus any penalties and interest;
(8) telephone, television, or radio for personal use of client;
(9) retainers, unless itemized services of equal value have been rendered;
(10) fines or penalties;
(11) ancillary costs that are billable to Medicare or other third party payers;
(12) property taxes and other expenses related to real estate deemed by the Division of Medical Assistance to be in excess of the reasonable amount needed for the physical facility;
(13) property taxes, insurance, maintenance and other expenses related to facility costs deemed by the Division of Medical Assistance to be in excess of the reasonable amount necessary for quality client care;
(14) costs associated with lawsuits filed against the Department of Health and Human Services which are not upheld by the courts;
(15) personal use of company assets resulting in unreasonable levels of compensation;
(16) meals provided to employees not involved in the modeling process required to meet the clients' habilitation plan;
(17) charitable contributions;
(18) costs, related to excessive or unnecessary levels of care;
(19) interest associated with Medicaid overpayment repayment plans agreed to by both the provider and the Division of Medical Assistance;
(20) costs related to frivolous appeals;
(21) costs resulting from provider negligence;

(22) costs related to any illegal activity;
(23) costs disallowed on the associated tax return by the Internal Revenue Service, or the North Carolina Department of Revenue unless specifically allowable under this plan;
(24) promotional items designed to promote the provider's public image;
(25) costs associated with the interests of provider shareholders and not direct care related;
(26) costs related to client care incurred in prior years, unless specific approval acquired from the Division of Medical Assistance; Approval of said costs shall be based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence on a case-by-case-review;
(27) country club dues.

(t) Providers shall use a competitive bidding process in order to purchase or lease vehicles.
(1) Providers shall explore cost differentials between leasing and purchasing of vehicles and shall choose the least expensive alternative.
(2) Daily logs detailing the use of vehicles shall be maintained by the provider.

(u) Purchase of services, major renovations, capital equipment, and supplies that exceed five thousand dollars ($5,000) annually per facility shall be reasonably made consistent with the prudent buyer provisions of the HCFA-15.

(v) Reasonable costs associated with self-insurance programs are allowable, as determined by the Division of Medical Assistance. All material facts related to said programs shall be disclosed to the Division of Medical Assistance. Failure to disclose shall result in the disallowance of said costs, unless failure to disclose the information was caused by reasons beyond the control of the provider.

PAYMENT ASSURANCE

.0306 PAYMENT ASSURANCES

(a) The State shall pay each provider of ICF-MR services in accordance with the requirements of the State plan and the Participation agreement, the amount determined under the plan.

(b) In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

(c) The payment methods and standards set forth herein are designed to enlist the participation of any provider who operates a facility both economically and efficiently. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan. This reimbursement plan is effective consistent with and on approval of the State Plan for Medical Assistance.

(d) In all circumstances involving third party payment, Medicaid is the payor or last resort.

(e) The State may withhold payments to providers under the following circumstances:

(1) If the State has an expectation that the provider will not expend the total prospective rate for reasonable and allowable patient care costs, the State may, at its discretion, withhold a portion of each payment so as to avoid a large amount due back to the State.

(2) Upon provider termination from the Medicaid Program the State may withhold a sum of reimbursement settlements for all previous periods, including the period in which the termination occurred, are completed.

(3) Upon determination of any sum due the Medicaid Program or upon instruction from a legally authorized agent of State or Federal Government, the State may withhold sums to meet the obligations identified.

(4) Upon written request of the provider, and with good cause shown, the Division of Medical Assistance may approve a repayment schedule in lieu of withholding funds.

(5) The State may withhold up to twenty (20) percent per month of a provider's payment for failure to file a timely cost report or other relevant information related to a facility's operation and requested by the Division of Medical Assistance. These funds shall be released to the provider after the cost report or the related information requested by the Division of Medical Assistance is acceptably filed. The provider shall experience delayed payment while the check is routed to the State and split for the amount withheld.

REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITIES

.0307 Reimbursement Methods for State-Operated Facilities

(a) A certified State-operated ICF-MR facility is reimbursed for the reasonable costs that are necessary to efficiently meet the needs of its clients and to comply with federal and state laws and regulations. Payments shall be suspended if annual reports are not filed. The Division of Medical Assistance may extend the deadline for filing the report if in its view good cause exists for the delay. The reasonableness and allowability of costs incurred by state-operated facilities shall be determined by the Division of Medical Assistance.

(b) A per diem rate based on the provider's estimated annual cost divided by patient days shall be used to make interim payments. A tentative settlement shall be issued based on the desk audit performed on each annual cost report to determine the amount of Medicaid reasonable cost and the amount of interim payments received by the provider.

(c) Any payments in excess of costs shall be refunded to the Division of Medical Assistance. Any reasonable costs in excess of payments shall be paid to the provider. An annual field audit may be performed by a qualified independent auditor to determine the final settlement amounts.

(d) ICF-MR Facility Assessments: An adjustment to the interim ICF-MR facility payment rate calculated in accordance with paragraph (c) of this section is established, effective July 1, 2004, to reimburse Medicaid participating State-Operated ICF-MR facilities for the provider's assessment costs that are incurred for the care of NC Medicaid residents. No adjustment will be made for the provider's assessment costs that are incurred for the care of private paying residents or others who are not Medicaid eligible.

RATE APPEALS

.0308 RATE APPEALS

(a) The Division of Medical Assistance shall consider only the following appeals for adjustment to the rates which would result in an annual rate increase to the provider from the Medicaid Program of one thousand dollars ($1,000) or more.

(1) Appeals because of changes in the information used to calculate a facility's prospective rate.

(2) Appeals for significant increases or decreases in a facility's overall base period operating costs due to, but not limited to, implementation of new programs, changes in staff or service, changes in the characteristics or number of clients, changes in a financing agreement, capital renovations, expansions or replacements which have been either mandated or approved by the Division of Medical Assistance and, except in life-threatening situations, approved in advance by the applicable State agencies.

(3) In order for said changes to be considered, they shall be consistent with all of the provisions of this plan.

(4) Upon proper notification to the provider in writing, the Division of Medical Assistance may instigate a proceeding to reduce the provider's rates. A rate reduction proceeding may be initiated upon the determination of just cause by the Division of Medical Assistance. Grounds for just cause may include, but are not limited to, the following:

(A) The provider has achieved material over-collections of Medicaid funds derived from the prospective rate being greater than reasonable Medicaid costs.

(B) Changes in Federal or State laws or regulations resulting in material operational cost savings.

(C) Material changes in client profile resulting in the need for less costly services.

(D) The burden of proof shall be on the Division of Medical Assistance to prove the need for said rate reduction.

(5) In determining a fair and reasonable rate under appeal, the Division of Medical Assistance shall take into consideration all funds available to the provider from the Medicaid program and patient liability. Providers are expected to utilize all available funds to provide the services that their clients need.

(6) Reasonable occupancy factors, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, shall be utilized in establishing fair and reasonable rates in the appeal process.

(7) The Division of Medical Assistance shall not pay interest on the final dollar settlement resulting from the retroactive impact of any rate appeals.

(b) Notification of appeal:

(1) In order to appeal a rate the facility shall send to the Division of Medical Assistance an appeal application in writing within 60 days subsequent to the proposed effective date of the appeal rate.

(2) The appeal application shall set forth the basis for the appeal and the issues of fact. Appropriate documentation shall accompany the application and the Division of Medical Assistance may request in writing such additional documentation as it deems necessary.

(c) The burden of proof on appeal shall be on the facility to present clear and convincing evidence to demonstrate the rate requested in the appeal is necessary to ensure efficient and economical operation, and meets the criteria of this State Plan.

(d) There shall be written notification by the Division of Medical Assistance of the final decision on the facility's rate appeal. However, at no point in the appeal process shall the facility have a right to an interim report of any determinations made by any of the parties to the appeal.

AUDITS

.0309 AUDITS

(a) Each facility shall maintain the statistical and financial records which formed the basis of the reports required by this plan and submitted to the Division of Medical Assistance for five years from the date on which the reports were submitted or due, whichever is later, or for such longer periods as may be required under State or Federal law. Each cost report shall be verified by the state agency or its representative for completeness, accuracy, and reasonableness through a desk audit. Field audits shall be performed as required. When a combined cost report is filed under this plan, only the combined cost report is subject to desk and field audit, unless the Division of Medical Assistance determines that the supporting individual facility cost reports need to be audited.

(b) All such records shall be subject to audit for a period of five years form the later of the date on which all required reports were filed with the Division of Medical Assistance or the date on which such reports were due.

(1) Desk or field audits shall be conducted by the Division of Medical Assistance, its designated contract auditors, or other governmental agencies at a time and place and in a manner determined by said governmental agencies.

(2) The audits may be performed on any financial or statistical records required to be maintained.

(3) Any findings of any above-described audit shall constitute grounds for recoupment at the discretion of the Division of Medical Assistance, provided that such audit finding relates to the allowable costs.

(c) All filed cost reports shall be desk audited and tentative settlements made in accordance with the provisions of this plan. This settlement is issued within 180 days of the date the cost report was filed or within 272 days of the end of the June 30 fiscal year reflected in the cost report, whichever is later. The state may elect to perform field audits on any filed cost reports within three years of the date of filing and issue a final settlement on a time schedule that conforms to Federal law and regulation. If the state decides not to field audit a facility a final reimbursement notice may be issued based on the desk audited settlement. The state may reopen and field audit any cost report after the final settlement notice in order to comply with Federal law and regulation or to enforce laws and regulations prohibiting abuse of the Medicaid Program and particularly the provisions of this reimbursement plan.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Payment for ICF/MR Services:

FY 2003 – No adjustment

FY 2004 – No adjustment.

FY 2005 – With the implementation of the assessment process and the analysis of justified costs, agreement was reached with the industry to only provide a 1% inflationary increase to be included in the 7% increase in their rates.